Carmel Fire Department Ambulance Signature Form – Version 2.0

ıtient Name:			Transport Date:	
vacy Practices Ackı	nowledgment: by signin	ig below, the signer ackno	wledges that [Carmel Fire Dep	artment (CFD)] provided a copy of its Notice of Privacy
		ctions to provide the Notic	ce to the patient.	
		*A copy of the	his form is valid as an original	*
		SECTION I	- PATIENT SIGNATU	<u>RE</u>
			the patient is physically or mentall	
	NOI	E. If the patient is a minor,	the parent or legal guardian should	i sign in this section.
uture, until such time egardless of my insu mmediately remit to uch payments to [CI my holder of medical and Medicaid Service	e as I revoke this authorize rance coverage, and in so [CFD] any payments the FD]. I authorize [CFD] to I information or other rel	zation in writing. I unders ome cases, may be respon at I receive directly from i o appeal payment denials levant documentation abours ors or insurers, and their re	tand that I am financially respon sible for an amount in addition to nsurance or any source whatsoes or other adverse decisions on my at me to release such information	vices provided to me by [CFD] now, in the past, or in the sible for the services and supplies provided to me by [CFI] that which was paid by my insurance. I agree to ver for the services provided to me and I assign all rights to behalf without further authorization. I authorize and direct to [CFD] and its billing agents, the Centers for Medicare is may be necessary to determine these or other benefits
			If the patient signs with an "X"	or other mark, a witness should sign below.
v			V	
X Patient Signature o	r Mark	Date	X Witness Signature	Date
E .				
			W7:4 A J.J	
	<u>SECTION</u>	<u>ON II - AUTHORI</u>	ZED REPRESENTATI	<u>VE SIGNATURE</u>
(Complete this sect	tion only if the nat	rient is physically or me	entally incapable of signing.
`	complete tins see	tion <u>only</u> if the pat	icht is physically of me	many incapable of signing.
On the line below,	explain the circumstan	ces that make it impracti	ical for the patient to sign:	
•	•	•	•	
below. My signatu	re is not an acceptance		iv tor the services rendered	
Patient's legal g Relative or othe Relative or othe Representative	er person who receives so er person who arranges fo	following individuals: ocial security or other gov for the patient's treatment	rernmental benefits on behalf of or exercises other responsibility	
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□ Patient's legal g □ Relative or othe □ Relative or othe □ Representative services, or ass	guardian er person who receives so er person who arranges fo of an agency or institution iistance to the patient	following individuals: ocial security or other gov for the patient's treatment of that did not furnish the Date Printer	ernmental benefits on behalf of the control of exercises other responsibility services for which payment is clud Name and Address of Representations.	for the patient's affairs aimed (i.e., ambulance services) but furnished other care, sentative
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